State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
(804) 371-9913

APPEAL OF FINAL ADVERSE DECISION FORM

If you meet the definition of an **appellant**[1], and have had a request for approval of health care service(s) denied by a **Managed Care Health Insurance Plan (MCHIP)**, you may have the right to an external review of the **MCHIP's** decision. An **impartial health entity** selected by the Bureau of Insurance will review the appropriateness of the **MCHIP's** decision, and make a recommendation to the Commissioner of Insurance as to whether the health care service(s) should be covered. In order for such a review to occur, the **appellant** must complete and sign this form. Additionally, the appeal in question must meet the following criteria:

1. The **cost of service** in question must exceed $300;
2. The appeal must be filed within 30 days of the **final adverse decision** by the **MCHIP**;
3. The **MCHIP's** internal appeal process must have been exhausted (except for **expedited reviews**); and
4. A $50 filing fee must be submitted with this form by check or money order made payable to the Treasurer of Virginia. This fee may be waived or refunded if it can be demonstrated that paying the fee constitutes a financial hardship to the **covered person** (see item 7 on the following page); and is refundable if the appeal is not accepted for review.

Additional instructions and definitions of key terms for completing this form are attached. If you have questions while completing this form or if you have questions that are not addressed in the instruction form, you may contact The Office of the Managed Care Ombudsman toll free at (877) 310-6560, or locally at (804) 371-9032, for assistance.

The decision reached as a result of this external review process is binding upon the **covered person** as well as the issuer of the **covered person**'s policy to the same extent that each would be bound by a judgment entered in a court action at law or in equity.

I request an external review of the **MCHIP's final adverse decision** by an **impartial health entity** as chosen by the Bureau of Insurance. I certify that the **covered person**'s **MCHIP's** internal appeals have been exhausted, or that the requirements for an **expedited review** have been met.

(Please type or print clearly all requested information in the spaces provided, or use additional pages, if necessary.)

1. Name of the **Covered Person**:_____

   Address:_____

   _____

   City:_____ State:_____ Zip:_____

   Daytime Phone Number(s):_____

   Date of Birth:_____ Sex:_____

   ID# (Policy or Certificate Number):_____

2. If you are an **appellant other than** the **covered person**, please tell us your name and what your relationship is with the **covered person**:_____

   _____

[1] Words in bold type are defined key terms.

3. Complete Name of **MCHIP**:_____

   Address:_____

   _____

   City:_____State:_____Zip:_____

   Phone Number:(___)_____

   Is this health coverage provided through an employer? ☐ Yes ☐ No

   If yes, please provide the employer's name, address, and telephone number:_____

   _____

   _____

   _____

4. On a separate sheet of paper, please describe the situation you are seeking help with and describe the service(s) or procedure(s) in question:

   Please send us a copy of the letter informing the **covered person** of the **MCHIP's final adverse decision.**

5. Are you requesting an **expedited review**? ☐ Yes ☐ No

   If yes, please provide documentation that the **covered person**'s situation involves an **emergency medical condition.**

6. **a.** In the opinion of the covered person's health care provider, is the covered person's condition terminal without this treatment? ☐ Yes ☐ No If Yes, continue to **b.** If No, skip to question 7.
   b. Has the requested treatment already been provided? ☐ Yes ☐ No If Yes, skip to question 7. If No, continue to **c.**
   c. Do you plan to delay the treatment requested while awaiting this external appeal decision? ☐ Yes ☐ No

7. Are you requesting a waiver of the $50 filing fee? ☐ Yes ☐ No

   If yes, please provide the reason and documentation to support the claim that paying the $50 filing fee would cause financial hardship to the **covered person.**

8. The estimated total cost of the denied services to the covered person: $_____.

AUTHORIZATION

I understand and agree that a copy of this form and any information I provide may be forwarded to the **MCHIP** and to the **impartial health entity.**

_____ _____

Signature of **Appellant** (if not the **Covered Person**) Date

_____ _____

Signature of **Covered Person** or Other Authorized Signature Date